STATEMENT FOR CRIME VICTIM MENTAL HEALTH SERVICES

Department of Labor & Industries
Crime Victims Compensation Program
PO Box 44520
Olympia WA 98504-4520

Claim Number
V -

DO NOT WRITE IN SPACE >

CLAIMANT'S NAME IN FULL Last	First	Middle	Social Security Number (for ID only)	Date of injury
Address			Date of Birth	Referring provider's provider No.
City	State	ZIP	Name of referring provider or other source	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM, DSM III or DSM IV)
Designate left or right when applicable.

1.
2.
3.
4.
5.

Give hospitalization dates for inpatient services

Admitted ____/____/____

Discharged ____/____/____

ENTER ONLY ONE ITEM PER LINE Date of Service	POS	TOS	Procedure Code	Mod Code	Describe services provided	If mental health patient is not victim, give name and the relationship to victim.	Charges $	Unit	To Date of Service
1.									
2.									
3.									
4.									
5.									
6.									
7.									

The submission of this bill certifies that the material furnished, the service(s) provided, expense incurred, or any other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington; that the claim is just and due.

Provider of Service Name	Individual Provider No.	Total Charge
Group, Clinic, Center or Facility Name	Group Provider No.	Phone Number
Address		Your Patient's Account Number
City	State ZIP + 4	
Federal Tax ID Number ☐ EIN ☐ SSN		

Signature	Bill Date / /	Amount Paid by Primary Insurance $	Name of Primary Insurance Company -

PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED

INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MENTAL HEALTH SERVICES BILLING FORM

Crime Victims is a secondary insurer. Submit bills to public or private insurance first.

1. **CLAIM NUMBER:** For the claimant receiving services. **Billings CANNOT be processed without the claim number.**
2. **CLAIMANT'S NAME:** Clearly print or type the claimant's full name.
3. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. This helps when the claim number is wrong and the claimant's name is common.
4. **DATE OF INJURY:** This is important and must be included. One person may have several claims; therefore, it is vital the proper claim is identified and charged for services provided. The date of injury positively identifies each claim.
5. **ADDRESS:** Enter the claimant's current address.
6. **DATE OF BIRTH:** Enter claimant's date of birth.
7. **REFERRING PROVIDER'S PROVIDER NUMBER:** Enter the CVC provider number designated for the referring provider. The number may be obtained from the referring provider.
8. **NAME OF REFERRING PROVIDER:** The name of the provider who has referred claimant to you for services.
9. **DIAGNOSIS:** Indicate both ICD-9-CM, DSM III or DSM IV code number and the narrative diagnosis for all conditions treated. Designate left or right side of body when applicable.
10. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
11. **ITEMIZATION OF SERVICES AND CHARGES:**
    - A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., special programs, self-defense courses, etc.) record both the beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
    - B. **PLACE OF SERVICE (POS):** Place of Service (POS) codes are printed below. Place the appropriate code in the space provided.
    - C. **TYPE OF SERVICE (TOS):** Type of Service (TOS) codes are listed below. Place the appropriate code in the space provided.
    - D. **PROCEDURE CODE:** Procedure codes can be found in the **Crime Victim's Compensation Mental Health Treatment Rules and Fee Schedule** and/or the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Dept of Labor and Industries.
    - E. **CODE MODIFIER:** A modifier provides the means by which the reporting provider can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modified code number" (including the hyphen) after the usual procedure code number.
    - F. **DESCRIBE SERVICES PROVIDED:** Give narrative description of services provided.
    - G. **MENTAL HEALTH -** If mental health patient is not the claimant, give the name and relationship to claimant. Mental health patients must be identified on each line billed if patient is not the claimant.
    - H. **CHARGES:** Total of charges per each line.
    - I. **UNIT:** The sum total of services provided for days, anesthesia time units, hours, miles, etc. per line. USE **WHOLE** NUMBERS ONLY.
    - J. **TOTAL CHARGE:** Total of **all** charges for services provided.
12. **PROVIDER OF SERVICE:** Name of person actually providing treatment or service. This information is required for persons providing treatment in a group, clinic, center or facility setting.
13. **INDIVIDUAL PROVIDER NUMBER:** Enter provider of services CVC provider account number.
14. **GROUP, CLINIC, CENTER OR FACILITY NAME:** If the provider of service is associated with a group, clinic, center or facility, identify with the name on this line.
15. **GROUP PROVIDER NUMBER:** If payment is to be made to a group/clinic rather than to the provider, enter the group/clinic number designated by CVC. This applies only to provider groups where the group/clinic has been assigned a main number and the members of the group have been assigned individual numbers.
16. **ADDRESS:** Address given for billing purposes.
17. **YOUR PATIENT'S ACCOUNT NUMBER:** Your internal patient account number.
18. **AMOUNT PAID BY PRIMARY INSURANCE:** As Crime Victims Compensation is a secondary insurer, public (DSHS) or private insurance must be billed first. Enter amount paid by public or private insurance.
19. **FEDERAL TAX IDENTIFICATION NUMBER:** Enter provider's IRS (Internal Revenue Service) federal tax identification number. Indicate by marking box whether federal tax ID number is EIN or SSN.
20. **NAME OF PRIMARY INSURANCE COMPANY:** Enter name of public (DSHS) or private insurance company making payments on the claimant's behalf.

REQUIRED ATTACHMENTS:

The following attachments must be submitted with billing for appropriate services:

NOTE: Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

1. Explanation of Benefits
2. X-Ray findings
3. Lab reports
4. Operative reports
5. Emergency room reports
6. Diagnostic study reports
7. Cost invoice of supplies Furnished
8. Consultation reports

PLACE OF SERVICE (POS)

- 03 School
- 04 Homeless Shelter
- 05 Indian Health Service Free-standing Facility
- 06 Indian Health Service Provider-based Facility
- 07 Tribal 638 Free-standing Facility
- 08 Tribal 638 Provider-based Facility
- 11 Office
- 12 Patient's Home
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Rm - Hospital
- 24 Ambulatory Surgical Ctr
- 25 Birthing Center
- 26 Military Trmt Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 35 Adult Living Care Facility
- 41 Ambulance - Land
- 42 Ambulance - Air or Water
- 50 Federally Qualified Hlth Ctr
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Facility Partial Hospitalization
- 53 Community Mental Health Ctr
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Abuse Trmt Facility
- 56 Psychiatric Residential Trmt Ctr
- 60 Mass Immunization Ctr
- 61 Comprehensive Inpatient Rehabilitation Facility
- 62 Comprehensive Outpatient Rehabilitation Facility
- 65 End Stage Renal Disease Trmt Facility
- 71 State or Local Public Health Clinic
- 72 Rural Hlth Clinic
- 81 Independent Laboratory
- 99 Other Unlisted Facility

TYPE OF SERVICE (TOS)

- C Chiropractic Services
- D Drugless Therapeutics
- I Inpatient
- M Mental Health Counselors
- N Nurse Practitioners
- O Outpatient
- P Physical Therapy
- V Vocational Services
- 3 Medical services including Psychiatrists and Psychologists
- 4 Dental
- 9 Ancillary Services (equipment, glasses, etc.)